ISSUANCES AFFECTED: A. REFERENCES None

B. RESCISSIONS None

BACKGROUND: Many acronyms are used with programs administered by federal and state entities.

The following list of acronyms is provided to assist the user of this manual.

ADA	Americans with Disabilities Act
ADC	Aid to Dependent Children
AFDC	Aid to Families with Dependent Children
BC&JOS	Building Check and Job Order Sheet
CAA	Community Action Agency
CAP	Community Action Plan
CAP	Community Action Program
CAP	Corrective Action Plan
CAP	Cost Allocation Plan
CSBG	Community Services Block Grant
DOE	U.S. Department of Energy
FAP	Food Assistance Program (Formerly Food Stamps)
FIA	Family Independence Agency
FIP	Family Independence Program (Formerly ADC)
FIS	Family Independence Specialist
GPRA	Government Performance and Results Act
HHS	U.S. Department of Health and Human Services
LCA	LIHEAP Crisis Assistance
LIHEAP	Low Income Home Energy Assistance Program
LWO	Local Weatherization Operator
MPSC	Michigan Public Service Commission
NASCSP	National Association for State Community Services Program
NEAT	National Energy AudiT
OMB	U.S. Office of Management and Budget
POI	Pollution Occurrence Insurance
PY	Program Year
ROMA	Results Oriented Management & Accountability
SDA	State Disability Assistance
SEF	State Emergency Funds
SER	State Emergency Relief
SFA	State Family Assistance
SSI	Supplemental Security Income

TANF	Temporary Assistance for Needy Families
T/TA	Training and Technical Assistance
WAP	Weatherization Assistance Program
WFM	Weatherization Field Manual
WGM	Weatherization Guidance Memo
WPN	Weatherization Program Notice
WX	Weatherization

LCA Programmatic and Narrative Report
Michigan Family Independence Agency
Due Quarterly (Jan 15th - Apr 15th – Jul 15th – Oct 15th)

Grantee Name:
Period Covered:

SECTION I – Required Programmatic Data

	This Quarter		Year to Date	
	Households	**Expenditures**	**Households**	**Expenditures**
Heat		**$**		**$**
Electric		**$**		**$**
Deposits		**$**		**$**
Connection, Reconnection or Hookups		**$**		**$**
TOTAL		**$**		**$**

SECTION II – Completion required once a year. Due on October 15th .

Significant problems encountered:

Significant accomplishments:

Recommendations to improve this program, ideas for future projects:

Authority: P.L. 97-35 of 1981 Response: Mandatory Penalty: No Reimbursement	The Family Independence Agency will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to an FIA office in your county.

Narrative Report

Michigan Family Independence Agency

Contractor Name:_____ Contract #_____

Report Covers_____through_____

Failure to submit the Narrative Report timely may cause a delay in the processing of Statement of Expenditures. Narrative Reports are due 15 days after each quarter. The quarters end on December 31, March 31, June 30, and September 30, unless otherwise indicated in the contract. Narrative Reports should be mailed to your grant manager at Suite 1314, P.O. Box 30037, 235 S. Grand Ave, Lansing MI. 48909

Describe the activities conducted to achieve the tasks listed in the contract Statement of Work:

Please attach additional sheets, as necessary

FIA-129 (5/97)

TANF Programmatic Narrative Report

Michigan Family Independence Agency

Grantee Name:

Grant Number: Grant Period:

For each TANF-funded service or activity your agency provided, please describe the following:

- **the target population,**
- **how your program operated, including the coordination with other agencies,**
- **the results achieved,**
- **how TANF funds supported or enriched other programs.**

(Please attach additional pages as necessary)

Grantee Signature	Title	Date

FIA-303 (10/00)

CSBG-E Agreement
Earned Income Tax Credit Program
Programmatic and Narrative Report

Michigan Family Independence Agency
Due May 15, 2004 (for period 1/1/04—04/15/04)
- Complete Section I
Due July 31, 2004 (for period 1/1/04—06/30/04)
- Complete Sections I, II , III and IV

Grantee Name:

Report Period Covered:

SECTION I – Programmatic Data - all data must be cumulative for each reporting period

A: TOTAL # of households served (unduplicated count):

B. TOTAL # of household members (unduplicated count):

C. Complete columns 1, 2 and 3 below :

TYPE OF RETURN OR CREDIT	# OF FORMS COMPLETED To Date (1)	# OF RETURNS/ FORMS E-FILED To Date (2)	$ TOTAL AMOUNT CREDITED or REFUNDED (3)
FEDERAL Income Tax Return			
- EARNED INCOME Tax Credit			
STATE Income Tax Return			
- HOME HEATING Tax Credit			
- HOMESTEAD PROPERTY Tax Credit			
LOCAL Income Tax Return			
AMENDED or **PREVIOUS YEAR** Tax Returns			
TOTAL			

D. TOTAL # of volunteer hours contributed to the program:

Narrative Report

SECTION II (attach additional pages as necessary)

Please describe any special "success" stories, attributed to the EITC program, experienced by your clients.

CSBG-E Agreement
Earned Income Tax Credit Program
Programmatic and Narrative Report

Michigan Family Independence Agency

Due May 15, 2004 (for period 1/1/04—04/15/04)

- Complete Section I

Due July 31, 2004 (for period 1/1/04—06/30/04)

- Complete Sections I, II, III and IV

Narrative Report – continuation-

SECTION III (attach additional pages as necessary)

A. Significant program accomplishments:

B. Significant problems encountered during program implementation:

C. Recommendations to improve implementation of this program in the future:

SECTION IIV (attach additional pages as necessary)

A. Attach a copy of any outreach materials used for this program. How were these materials distributed?

B. What, if any, community providers referred clients to the agency for this service?

Authority: P.L. 97-35 of 1981 Response: Mandatory Penalty: No Reimbursement	The Family Independence Agency will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to an FIA office in your county.

MPSC Programmatic and Narrative Report
Michigan Family Independence Agency
Due: May 15 for the period January 1 – April 30
August 15 for the period May 1 – July 31

Grantee Name:
Period Covered:

SECTION I – Required Programmatic Data

	This Period	Year to Date
Number of Households served		
Number of Households with a child or pregnant woman		
Expenditures for Households with a child or pregnant woman	**$**	
Number of Eligible Households denied assistance due to lack of funds		

Section II – Program Outreach Materials (Attach all outreach materials used in the program)

SECTION III – Completion required once a year. Due on August 15th .

Significant problems encountered:

Significant accomplishments:

Recommendations to improve this program, ideas for future projects:

Authority: P.L. 97-35 of 1981 Response: Mandatory Penalty: No Reimbursement	The Family Independence Agency will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to an FIA office in your county.

COMMUNITY ACTION AGENCY BOARD ROSTER
FAMILY INDEPENDENCE AGENCY

AUTHORITY: PA 230 OF 1981 COMPLETION: MANDATORY PENALTY: FUNDS NOT RELEASED	The Family Independence Agency will not discriminate against any individual or group because of race, religion, color, national origin, sex, age, height, weight, marital status, handicap, or arrest without conviction.

Instructions: The Roster must be completed/updated and submitted as follows: · as part of the agency's annual CSBG community action plan, · within 30 days following the agency's annual elections, · and within 30 days following chairperson/president changes.

I. IDENTIFICATION

AGENCY NAME	**DATE OF COMPLETION**

NAME OF CURRENT (√ ONE) ☐ CHAIRPERSON ☐ PRESIDENT	**NAME OF CURRENT** (√ ONE) ☐ VICE-CHAIRPERSON ☐ VICE-PRESIDENT

BOARD STRUCTURE (√ As Appropriate)	**DATE (Mo.) OF ANNUAL ELECTION**	**BOARD MEETING SCHEDULE** (Describe - From Agency By-Laws)	**TOTAL NUMBER OF BOARD MEMBERSHIP** (From Agency By-Laws)
☐ GOVERNING BOARD ☐ (&) ADVISORY BOARD			

II. BOARD MEMBERSHIP REPRESENTATION · For Private Non-Profit and Public Entities

- **CONSUMER SECTOR**

  The Master Agreement requires that: **not fewer than one-third of the members are persons chosen in accordance with democratic selection procedures adequate to assure that they are representative of low-income individuals and families in the neighborhood served; and each representative of low-income individuals and families selected to represent a specific neighborhood within a community resides in the neighborhood represented by the member.** And, **for Public Entities**, that: **these members are able to participate actively in the development, planning, implementation and evaluation of programs funded under CSBG.**

  Enter the number of **CONSUMER SECTOR** representatives (from Agency By-Laws):

- **PUBLIC SECTOR**

  The Master Agreement requires that: **one-third of the members of the board are elected public officials, currently holding office, or their representatives, except that if the number of elected officials reasonably available and willing to serve is less than one-third of the membership of the board, membership on the board of appointive public officials or their representatives may be counted in meeting such one-third requirement**.

  Enter the number of **PUBLIC SECTOR** representatives (from Agency By-Laws):

- **PRIVATE SECTOR**

  The Master Agreement requires that: **the remainder of the members are officials or members of business, industry, labor, religious, law enforcement, education, or other major groups and interests in the community served.**

  Enter the number of **PRIVATE SECTOR** representatives (from Agency By-Laws):

III. BOARD MEMBERSHIP ➢ CONSUMER SECTOR

- Identify each Consumer sector representative below. If the member is not a consumer/low-income individual, include the name of the organization or specific neighborhood the member is representing.
- Each Board member vacancy must be included and listed as "**VACANT**" along with the **month and year** when the vacancy occurred. (Use continuation page as necessary)

NAME: (√ ONE) ☐ CONSUMER ☐ REPRESENTS CONSUMER - Org/Neigh:________________	Total Years Served	COUNTY
ADDRESS	CITY	ZIP CODE
NAME: (√ ONE) ☐ CONSUMER ☐ REPRESENTS CONSUMER - Org/Neigh:________________	Total Years Served	COUNTY
ADDRESS	CITY	ZIP CODE
NAME: (√ ONE) ☐ CONSUMER ☐ REPRESENTS CONSUMER - Org/Neigh:________________	Total Years Served	COUNTY
ADDRESS	CITY	ZIP CODE
NAME: (√ ONE) ☐ CONSUMER ☐ REPRESENTS CONSUMER - Org/Neigh:________________	Total Years Served	COUNTY
ADDRESS	CITY	ZIP CODE
NAME: (√ ONE) ☐ CONSUMER ☐ REPRESENTS CONSUMER - Org/Neigh:________________	Total Years Served	COUNTY
ADDRESS	CITY	ZIP CODE
NAME: (√ ONE) ☐ CONSUMER ☐ REPRESENTS CONSUMER - Org/Neigh:________________	Total Years Served	COUNTY
ADDRESS	CITY	ZIP CODE
NAME: (√ ONE) ☐ CONSUMER ☐ REPRESENTS CONSUMER - Org/Neigh:________________	Total Years Served	COUNTY
ADDRESS	CITY	ZIP CODE
NAME: (√ ONE) ☐ CONSUMER ☐ REPRESENTS CONSUMER - Org/Neigh:________________	Total Years Served	COUNTY
ADDRESS	CITY	ZIP CODE
NAME: (√ ONE) ☐ CONSUMER ☐ REPRESENTS CONSUMER - Org/Neigh:________________	Total Years Served	COUNTY
ADDRESS	CITY	ZIP CODE

IV. BOARD MEMBERSHIP ➢ PUBLIC SECTOR

- Identify each Public sector representative below and include the Public Office the member is representing. If the member is "**representing**" a public official, include the name of the public official and their public office.
- Each Board member vacancy must be included and listed as "**VACANT**" along with the **month and year** when the vacancy occurred. (Use continuation page as necessary)

NAME: ☐ Public Official - Name of Public Office: ________________ ☐ Representing P.O. - Name of Public Official:________________ Office: ________________ -	Total Years Served	COUNTY
ADDRESS	CITY	ZIP CODE
NAME: ☐ Public Official - Name of Public Office: ________________ ☐ Representing P.O. - Name of Public Official:________________ Office: ________________ -	Total Years Served	COUNTY
ADDRESS	CITY	ZIP CODE
NAME: ☐ Public Official - Name of Public Office: ________________ ☐ Representing P.O. - Name of Public Official:________________ Office: ________________ -	Total Years Served	COUNTY
ADDRESS	CITY	ZIP CODE
NAME: ☐ Public Official - Name of Public Office: ________________ ☐ Representing P.O. - Name of Public Official:________________ Office: ________________ -	Total Years Served	COUNTY
ADDRESS	CITY	ZIP CODE
NAME: ☐ Public Official - Name of Public Office: ________________ ☐ Representing P.O. - Name of Public Official:________________ Office: ________________ -	Total Years Served	COUNTY
ADDRESS	CITY	ZIP CODE
NAME: ☐ Public Official - Name of Public Office: ________________ ☐ Representing P.O. - Name of Public Official:________________ Office: ________________ -	Total Years Served	COUNTY
ADDRESS	CITY	ZIP CODE

V. BOARD MEMBERSHIP ➢ PRIVATE SECTOR

- Identify each Private sector representative below and include the name and type (business, industry, labor, religious, law enforcement, education, human services, etc.) of organization the member is representing.
- Each Board member vacancy must be included and listed as "**VACANT**" along with the **month and year** when the vacancy occurred. (Use continuation page as necessary)

NAME: Organization:	Type:		Total Years Served	COUNTY
ADDRESS		CITY		ZIP CODE
NAME: Organization:	Type:		Total Years Served	COUNTY
ADDRESS		CITY		ZIP CODE
NAME: Organization:	Type:		Total Years Served	COUNTY
ADDRESS		CITY		ZIP CODE
NAME: Organization:	Type:		Total Years Served	COUNTY
ADDRESS		CITY		ZIP CODE
NAME: Organization:	Type:		Total Years Served	COUNTY
ADDRESS		CITY		ZIP CODE
NAME: Organization:	Type:		Total Years Served	COUNTY
ADDRESS		CITY		ZIP CODE
NAME: Organization:	Type:		Total Years Served	COUNTY
ADDRESS		CITY		ZIP CODE
NAME: Organization:	Type:		Total Years Served	COUNTY
ADDRESS		CITY		ZIP CODE
NAME: Organization:	Type:		Total Years Served	COUNTY
ADDRESS		CITY		ZIP CODE
NAME: Organization:	Type:		Total Years Served	COUNTY
ADDRESS		CITY		ZIP CODE

MODIFICATION REQUEST

FAMILY INDEPENDENCE AGENCY

AUTHORITY: PA 230 OF 1981 COMPLETION: MANDATORY PENALTY: NON-ACCEPTANCE OF DOCUMENT	THE FAMILY INDEPENDENCE AGENCY WILL NOT DISCRIMINATE AGAINST ANY INDIVIDUAL OR GROUP BECAUSE OF RACE, SEX, RELIGION, AGE, NATIONAL ORIGIN, COLOR, MARITAL STATUS, DISABILITY, OR POLITICAL BELIEFS.

1. GRANTEE NAME AND ADDRESS	2. PROGRAM NAME AND AGREEMENT NUMBER

3. PERIOD OF AGREEMENT	4. EFFECTIVE DATE OF MODIFICATION

5. EXPLANATION FOR MODIFICATION REQUEST	Revised narrative and/ or budget documents must accompany this request.

6. SIGNATURE OF EXECUTIVE DIRECTOR	
	DATE

SUMMARY OF WORK PROGRAM AND BUDGET

MICHIGAN FAMILY INDEPENDENCE AGENCY

1
PLANNED PROGRAM PERIOD

BEGINNING	ENDING

2
NAME OF AGENCY:

3
FUNDING SOURCE (T ONE)

_____ **CSBG**
_____ **OTHER:**

AUTHORITY: PA 230 OF 1981
COMPLETION: MANDATORY
PENALTY: NO FUNDS RELEASED

THE MICHIGAN FAMILY INDEPENDENCE AGENCY WILL NOT DISCRIMINATE AGAINST ANY INDIVIDUAL OR GROUP BECAUSE OF RACE, SEX, RELIGION, AGE, NATIONAL ORIGIN, COLOR, MARITAL STATUS, DISABILITY OR POLITICAL BELIEFS.

4 PROGRAM ACCOUNT NUMBER AND NAME	5 CSBG BUDGET		6		7		
	STATE SHARE	MATCH SHARE	STATE SHARE	MATCH SHARE	STATE SHARE	MATCH SHARE	TOTAL
4.a. PA 01 - ADMINISTRATION	$	$ N/A	$ N/A	$ N/A	$ N/A	$ N/A	$ N/A
4.a.1. - T/TA Funds	$	$ N/A	N/A	N/A	$ N/A	$ N/A	$ N/A
4.b. PA 02 - DIRECT PROGRAM	$	$ N/A	$ N/A	$ N/A	$ N/A	$ N/A	$ N/A

4.b.-1 CATEGORIES	4.b.-2*	4.b.-3*
EMPLOYMENT	$	
EDUCATION	$	
INCOME MANAGEMENT	$	
HOUSING	$	
EMERGENCY SERVICES	$	
NUTRITION	$	
LINKAGES	$	
HEALTH	$	
SELF-SUFFICIENCY	$	

*** Figures are approximates and for planning purposes.**

8 TOTALS							
	$	$ N/A	$ N/A	$ N/A	$ N/A	$ N/A	$ N/A

9

SIGNATURE OF EXECUTIVE DIRECTOR:

DATE

SUMMARY OF WORK PROGRAM AND BUDGET

INSTRUCTIONS FOR COMPLETING

ITEM NO.

1. -- 3. Self-explanatory

4. No entry required

4.a. PA 01 - Administration

In column 5, enter the amount of CSBG funds budgeted for PA 01.
Columns 6 and 7 - NA.

4.a.1 T/TA Funds

In column 5, enter the amount of CSBG funds budgeted for PA 01.
Columns 6 and 7 - NA.

4.b. PA 02 - Direct Program

In column 5, enter the amount of CSBG funds budgeted for PA 02.
Colums 6 and 7 - NA.

4.b.-1 No entry required.

4.b.-2 PA 02 - Direct Program only

In column 5, enter the approximate amount of CSBG funds anticipated to be expended for each category listed under PA 02.

4.b.-3 PA 02 - Direct Program only

Column 6 - NA.

8. Enter TOTAL for column 5.

9. Sign the Summary

WORK PROGRAM
PART I
MICHIGAN FAMILY INDEPENDENCE AGENCY
Community Services Block Grant

1
PLANNED PROGRAM PERIOD

BEGINNING	**ENDING**

2
NAME OF AGENCY:

3
FUNDING SOURCE
(CHECK ONE)
____ CSBG
____ Other:_____

AUTHORITY: **PA 230 OF 1981**
COMPLETION: **MANDATORY**
PENALTY: **NO FUNDS RELEASED**

THE MICHIGAN FAMILY INDEPENDENCE AGENCY WILL NOT DISCRIMINATE AGAINST ANY INDIVIDUAL OR GROUP BECAUSE OF RACE, SEX, RELIGION, AGE, NATIONAL ORIGIN, COLOR, MARITAL STATUS, DISABILITY OR POLITICAL BELIEFS.

4

PROBLEMS TO BE ADDRESSED IN THE WORK PROGRAM:

Check those "Program Categories" developed in the attached Work Program - PART II.

PROGRAM CATEGORIES

____ Employment

____ Education

____ Income Management

____ Housing

____ Emergency Services

____ Nutrition

____ Linkages with Other Programs

____ Health

____ Self-Sufficiency

WORK PROGRAM
PART I
INSTRUCTIONS FOR COMPLETING

ITEMS 1-4: Self-Explanatory.

WORK PROGRAM
PART II
INSTRUCTIONS FOR COMPLETING

NOTE: **!** CAAs may develop a work program that:
1. Reflects only those activities **directly supported** by CSBG funds, **OR**
2. Reflects the agency=s overall activities which are **directly or indirectly** supported by CSBG funds.

! CAAs should refer to the NASCSP Glossary for service codes, service titles and service title descriptions.

ITEM/COLUMN NO.

1. Enter agency name.

2. Enter the name of the **Program Category** (e.g., Employment, Education, etc.) for the activities to be listed on the page (**one** program category per page).

3. Enter the **service code number** for the service title to be discussed in column 4; e.g., 1.1.

4. **FIRST:** Enter the full name of the Service Title as identified with the service code; e.g., Information & Referral.

   SECOND: For each service title, **provide a narrative description of the Agency=s Planned Activities under the Service Title**. Use additional Part II forms for continuation sheets as needed.

Note: Several Service Titles (with narrative descriptions) can be included on the same page. There is no need to develop a separate page for each Service Title.

5. Enter an AX@ for each unit of service (entered in column 6) that is **directly supported** (financially) with CSBG funds.

6. For each Service Title, enter the **type of unit of service** planned (relevant to the narrative description); e.g., Referral, Round Trip, Meal, Completed Tax Form, etc.

WORK PROGRAM
PART II
MICHIGAN FAMILY INDEPENDENCE AGENCY
Community Services Block Grant

AUTHORITY: PA 230 OF 1981
COMPLETION: MANDATORY
PENALTY: NO FUNDS RELEASED

1
AGENCY NAME:

THE MICHIGAN FAMILY INDEPENDENCE AGENCY WILL NOT DISCRIMINATE AGAINST ANY INDIVIDUAL OR GROUP BECAUSE OF RACE, SEX, RELIGION, AGE, NATIONAL ORIGIN, COLOR, MARITAL STATUS, DISABILITY OR POLITICAL BELIEFS.

OBJECTIVES AND ACTIVITIES

2
PROGRAM CATEGORY NAME: _____

3 **CODE**	4 **1. Enter the applicable SERVICE TITLE from the NASCSP Glossary.** **2. Provide a Narrative description of the Agency=s Planned Activities under the Service Title.**	5 **SUPPORTED with CSBG (X)**	6 **TYPE OF UNIT OF SERVICE**

STAFF RESPONDENTS

Family Independence Agency

AUTHORITY : P.A. 230 of 1981 COMPLETION: MANDATORY PENALTY : NO FUNDS RELEASED	THE MICHIGAN FAMILY INDEPENDENCE AGENCY WILL NOT DISCRIMINATE AGAINST ANY INDIVIDUAL OR GROUP BECAUSE OF RACE, SEX, RELIGION, AGE, NATIONAL ORIGIN, COLOR, MARITAL STATUS, DISABILITY OR POLITICAL BELIEFS.

TO ASSIST STATE STAFF IN EXPEDITING THE PROCESSING OF THIS PLAN, PLEASE IDENTIFY AGENCY REPRESENTATIVES WHO CAN ANSWER SUBSTANTIVE AND TECHNICAL QUESTIONS ABOUT THE PLAN. CONTACT WILL BE MADE WITH THE IDENTIFIED INDIVIDUALS VIA TELEPHONE OR IN PERSON TO OBTAIN CLARIFICATION OR TO REQUEST ADDITIONAL INFORMATION.

NOTE: Respondent #1 should be the main contact regarding this plan. The agency is encouraged to identify the agency planner or program manager if this is appropriate (Rather than the executive director).

Respondent #1

Name: _____

Title: _____Phone No. _____ Email _____

Respondent #2

Name: _____

Title: _____Phone No. _____ Email _____

Respondent #3

Name: _____

Title: _____Phone No. _____ Email _____

Respondent #4

Name: _____

Title: _____Phone No. _____ Email _____

Weatherization Assistance Program Monthly Programmatic Report
Michigan Family Independence Agency

COMPLETION: MANDATORY PENALTY: FUNDS NOT RELEASED	THE MICHIGAN FAMILY INDEPENDENCE AGENCY WILL NOT DISCRIMINATE AGAINST ANY INDIVIDUAL OR GROUP BECAUSE OF RACE, SEX, RELIGION, AGE, NATIONAL ORIGIN, COLOR, MARITAL STATUS, DISABILITY OR POLITICAL BELIEFS.
REPORT MONTH/YEAR:	

SUMMARY	Plan (PYTD)	Actual (PYTD)	% of Plan	LOCAL WEATHERIZATION AGENCY	DATE RECEIVED
DOE Units					

A. TOTAL UNITS COMPLETED	DOE UNITS				DOE / LIHEAP UNITS				LIHEAP UNITS				TOTAL UNITS			
	MONTH		PYTD		MONTH		PYTD		MONTH		PYTD		MONTH		PYTD	
Weatherized Units Do not include reweatherized units / Reweatherized Units	**W**	**R**	**W**	**R**	**W**	**R**	**W**	**R**	**W**	**R**	**W**	**R**	**W**	**R**	**W**	**R**
1. Program Units																
B. UNITS BY TYPE																
1. Owner Occupied Units																
2. Single Family Rental Units																
3. Rental Units in a 2 - 4 Unit Building																
4. Rental Units in a 5+ Unit Building																
5. Mobile Home Owner Units																
6. Mobile Home Rental Units																
7. Shelter (Number of units)																
C. OTHER UNIT CATEGORIES																
1. Health & Safety Units																
2. Incidental Repair Units																
3. Total Partials Pending																
D. UNITS BY OCCUPANCY																
1. Elderly																
2. Disabled																
3. Native American																
4. FIP (Includes Food Stamps, SSI & SDA)																
5. Units at or below 125% of poverty																
E. TOTAL PERSONS ASSISTED																
1. Elderly																
2. Persons w/Disabilities																
3. Native American																

F. HOUSEHOLD INCOME - NOTE: COMPLETE FOR DOE/LIHEAP AND LIHEAP-ONLY UNITS

	MONTH	PYTD		MONTH	PYTD		MONTH	PYTD
1. Under $2,000			4. $6,001 - $8,000			7. $12,001 - $15,000		
2. $2,000 - $ $4,000			5. $8,001 - $10,000			8. $15,001 and over		
3. $4,001 - $6,000			6. $10,001 - $12,000			9. TOTAL UNITS		

CERTIFICATION: I certify that I am authorized to sign on behalf of the Local Weatherization Agency and that this is a true and correct statement of Programmatic data for the report period. Appropriate documentation is available and will be maintained for the required period.

Signature	Title	Telephone ( )	Date

J:\cspm\forms\1071f401

LIHEAP Activity Report

LWO_____ **Period covered: _____**

Weatherization measures (LIHEAP costs only)

Number of units	Type of Work	Total Materials & Labor Cost	Average Cost Per Unit
	Insulation--Attic		
	Insulation--Sidewall		
	Insulation--Foundation		
	Infiltration		
	Other Weatherization Measures		
	Total		

Replacement & Repairs using LIHEAP funds (Include only units in which some LIHEAP funds were used)

Number of units	Type of work	LIHEAP Funds	DOE Funds	* Other Funds	Total	Average Cost Per Unit
	New Furnace With Ductwork					
	New Furnace Without Ductwork					
	Furnace Repair					
	New Roof					
	Roof Repair					
	New Water Heater					
	Water Heater Repair					
	Other					
	Total					

* Other means **any** other funds including HUD programs, landlord contributions, client contributions, etc.

Number of units	Reason For Replacement (Indicate the PRIMARY reason for replacement)
	Furnace--Cracked Heat Exchanger
	Furnace--Inoperable
	Furnace--High Carbon Monoxide Level That Can Not Be Reduced To A Safe Level
	Furnace--Other Reasons
	Water Heater-- Inoperable
	Water Heater--Leaking
	Water Heater---Other Reasons

Describe how LIHEAP funds have been combined with your Weatherization Assistance Program (additional units completed for the year or extra measures installed on units that otherwise would have not been installed, etc.)
Please use the backside for additional comments

FIA-1073

Instructions For Completing The LIHEAP Activity Report

Weatherization Measures (LIHEAP costs only)

Enter the number of units for each type of work.
Enter the amount of LIHEAP funds used for total labor and materials.
Average Cost Per Unit (Total Materials and Labor divided by the Number of Units)

LIHEAP Replacement & Repairs (LIHEAP funds must be spent on unit)

Enter the number of units for each type of work.
Enter the amount spent from each funding source.
Average Costs for each type of work. (Total amount from all funding sources divided by the Number of Units)

Reason For Replacement

Enter the number of units by the primary reason for replacement. Do **not** include repair units in this section.

MICHIGAN FAMILY INDEPENDENCE AGENCY

State Emergency Funds (SEF) Program Activity Report

Grantee Name: Grant No. Grant Period:	
Type of Service	**Number of Households Served**
Information/Referral/Outreach	
Relocation Services	
Home Ownership Services	
Heat and Utility Services	
Household Contents	
Medication	
Other (Identify)	
Other (Identify)	
Other (Identify)	

Please list and indicate how SEF funds supported other critical needs programs:

Additional Comments:

Grantee Signature	Title	Date

FIA-1932 (6/99)

SEF -- Statement of Expenditures

STATE OF MICHIGAN
FAMILY INDEPENDENCE AGENCY

Original FIA Receipt
1. Grant Number

Section I - Complete For All Submittals

2. Subgrantee Name				3. Authorized FIA Signature (s)		
4. Report Month/Year		5. Approval Date	6.FE Number			
7. Agency	8.App. Year	9. Index	10. PCA	11. Agency Code	12. Agency Object	13. Mail Code

Section II - Bill Type

? Original ? Revised ? Final ? Other (Describe)

Section III - Reported Expenditures

BUDGET LINE ITEM	ALLOCATED BUDGET	PREVIOUSLY REPORTED EXPENDITURES	EXPENDITURES THIS PERIOD	EXPENDITURES YEAR-TO-DATE	BUDGET BALANCE
ADMINISTRATION					
CAA Emergency Funds					
Other					
Other					
Total Administration					
Information - Referral - Outreach					
DIRECT CLIENT SERVICES					
Relocation Services					
Home Ownership Services					
Heat and Utility Services					
Household Contents					
Medication					
Other					
Other					
Other					
TOTAL DIRECT CLIENT SERVICES					
TOTAL					

I certify that I am authorized to sign on behalf of the local agency and that this is a correct statement of expenditures for the report period identified above. Appropriate documentation is available and will be maintained for the required report period to support the reported costs.

Subgrantee Signature	Title	Date
AUTHORITY: P.A. 97-35 of 1981 COMPLETION: Mandatory PENALTY: No Reimbursement	The Family Independence Agency will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, political beliefs or disability.	

STATEMENT OF EXPENDITURES
Michigan Family Independence Agency

- **See instructions on reverse side.**
- **See P.A. 431 information and non-discrimination statement on reverse side.**

ORIGINAL FIA RECEIPT DATE (For FIA Use Only)	1. Contract Number

SECTION I – Complete for all Submittals

1A. Name of Contractor		2. Agency	3. App. Yr.	4. Index (5)	5. P.C.A.(5)	6. County	7. A. Obj. (4)
		431	FY02				
8. Period Covered by Statement FROM: THROUGH:		9. Authorized FIA Approval Signature(s)					10. Approval Date
11. F.E. Number (or) Social Security Number	12.Mail Code						

SECTION II – Bill Type

1.
☐ ORIGINAL ☐ REVISED ☐ FINAL ☐ OTHER

SECTION III – Dollars Expended to Provide Service to Eligible Clients

LISTED LINE ITEM BUDGET (Listed as specified in Budget Contained in Agreement to Purchase) (1)	DOLLAR AMOUNT In Budget (2)	Expended This Period (3)	Cumulative Expenditures to Date (4)
Salaries			
Fringe Benefits			
Occupancy			
Communication			
Supplies			
Equipment			
Local Transportation			
Contractual Services			
Specific Assistance to Individuals			
Miscellaneous			
TOTALS			

SECTION IV – Units Rendered to Provide Service to Eligible Clients

TYPE OF SERVICE (1)	Contract Rate Per Unit (2)	Number of Units Contracted (3)	Units Provided This Period (4)	Payment Amount This Period (5)	Cumulative Units to Date (6)	Cumulative Amount to Date (7)
TOTALS						

I hereby certify that the expenditures as stated in Section III represent actual expenditures made in accordance with the contract budget FIA-468; or that units of service provided as stated in Section IV have been provided.	Signature	Date

DISTRIBUTION:
PART 1 (White) – Payment Document Control
PART 2 (Green) – Program Office or Local Office
PART 3 (Canary) – Contract Coordinator
PART 4 (Pink) – Contract Initiator
PART 5 (Goldenrod) – Contractor

INSTRUCTIONS

Please Type or Print.
Section I – Complete for all submittals
Section II – Complete for all submittals
Section III – Complete for line item reimbursement only
Section IV – Complete for unit cost reimbursement

SECTION I

1. **Contract Number** – fill in the complete contract number, including the letter prefix as it appears in the upper right hand corner of the contract.

1A. **Name of Contractor** - fill in the business name exactly the way it is listed on the front page of your contract.

3. **App. Year** - Fill in the four digit appropriation year that funds are to be expended from.

4. **Index** – Fill in the five digit index number for the expenditure.

5. **P.C.A.** – Fill in the five digit program cost account for the expenditure.

6. **County** – County name.

7. **A. Obj.** – Fill in the four digit object code appropriate for the expenditure.

8. **Period Covered by Statement** – fill in the beginning and ending date of the calendar month(s) covered by this statement.

9. **Authorized FIA Approval Signature(s)** – to be completed by the Department.

10. **Approval Date** – to be completed by the Department.

11. **Federal Employer Number (or) Social Security Number** – fill in your federal identification number as it appears on Federal tax information. This is a nine digit figure. If you have no federal identification number your social security number may be used.

12. **Mail Code** – Fill in the three digit mail code which corresponds to the mail address.

SECTION II

1. **Original, Revised, Final** – check the appropriate box or use “Other” and explain.

SECTION III

(Col. 1) **Line Item Budget** – Budget categories are listed exactly in the order that they appear on the FIA-468, Budget Statement.

(Col. 2) **In Budget** – fill in the amounts allocated for each category in the contract. Amounts must adhere to approved line item changes, if any.

(Col. 3) **Expended this Period** – fill in the amount spent for each category in the period you are billing the department by actual expenditures of each line item.

(Col. 4) **Cumulative Expenditures to Date** – fill in the amount you have spent from the beginning date of the contract, including this billing period.

SECTION IV – If contract is paid by unit rate, complete ONLY Section IV.

(Col. 1) **Type of Service** – fill in the definition(s) of unit(s) as stated in the contract under Section II, Contractor Responsibilities.

(Col. 2) **Contract Rate Per Unit** – fill in the payment rate of each service as stated in the contract under Section III, Department Responsibilities – Payment.

(Col. 3) **Number of Units Contracted** – fill in the total number of units for each service this contract will allow as stated in the contract under Section II, Contractor Responsibilities.

(Col. 4) **Units Provided this Period** – fill in the number of units for each service used in this billing period.

(Col. 5) **Payment Amount this Period** – fill in the dollar amount of the units used in this billing period. This is the product of the contract rate per unit times the units provided this period. Total column, this is the amount you should expect to be paid.

(Col. 6) **Cumulative Units to Date** – fill in the total number of units used from the effective date of this contract to date.

(Col. 7) **Cumulative Amount to Date** – fill in the amount spent from the effective date of the contract to date. Total column.

SIGNATURE – Signature of person administratively responsible for the contract.

AUTHORITY: P.A. 280 1939.
COMPLETION: Mandatory.
PENALTY: No payment processed.

TANF -- Statement of Expenditures

STATE OF MICHIGAN -FAMILY INDEPENDENCE AGENCY

Original FIA Receipt

Grant Number **TANF-03-**

SECTION I—Complete

1. Name of Contractor	2. Agency	3. App. Yr.	4. Index	5. P.C.A.	6. County	7. A. Obj.
	431	FY03				

8. Period Covered by Statement FROM: THROUGH:	9. Authorized FIA Approval Signature(s)	10. Approval Date

11. F.E. Number	12.Mail Code

SECTION II – Bill Type

☐ ORIGINAL ☐ REVISED ☐ FINAL ☐ OTHER

SECTION III – Dollars Expended to Provide Service to Eligible Clients

LISTED LINE ITEM BUDGET	DOLLAR AMOUNT								
	Total Agreement Budget	Previous Admin Expended	Admin Expended This Period	**Total Admin YTD**	Previous Non-Admin Expended	Non-Admin Expended This Period	**Total Non-Admin YTD**	**TOTAL Expended THIS PERIOD**	**TOTAL Expended YTD**
Salaries									
Fringe Benefits									
Occupancy									
Communication									
Supplies									
Equipment									
Transportation									
Contractual Services									
Specific Assistance to Individuals									
Miscellaneous									
TOTALS							*		

SECTION IV – Number of Clients Served and Cost for Each Category of Service

TYPE OF SERVICE	Number of Clients YTD	Previous Expenditures	Expenditures this period	Expenditures YTD
Emergency Services				
Case Management **(goal oriented action plan)**				
Employment Support and Retention				
Family Self-sufficiency **(Classes, counseling, etc.)**				
Other—(provide description)				
Other—(provide description)				
TOTALS				*

I certify that I am authorized to sign on behalf of the local agency and that this is a correct statement of expenditures for the report period identified above. Appropriate documentation is available and will be maintained for the required report period to support the reported costs.

Signature Date

AUTHORITY: P.A. 97-35 of 1981
COMPLETION: Mandatory
PENALTY: No Reimbursement

The Family Independence Agency will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability.

FIA-3470 (08/02) *This figure should be the same in Section III and IV.

LINE ITEM TRANSFER REQUEST
Michigan Family Independence Agency

Contractor		Date
Contact Person	Phone Number	Contract Number
Address		Term of Contract (month/day/year) **TO**

LINE ITEM	LATEST APPROVED BUDGET	INCREASE	DECREASE	NEW APPROVED LINE ITEM BUDGET
Salaries				
Fringes				
Occupancy				
Communication				
Supplies				
Equipment				
Local Transportation				
Contractual Services				
Specific Assistance				
Miscellaneous				
TOTALS				

LINE ITEM **INCREASE(S):** State why line item(s) being increased must have additional funding. Be specific as to what cost items are affected, whether a cost item is being changed or added to the budget, etc.

LINE ITEM **DECREASE(S):** State why line item(s) being decreased will be underspent from projected levels. Be specific as to what cost items are affected, whether a cost item is being changed or deleted, etc.

IMPACT: What impact and impact magnitude will this change have on program performance? How will program be affected if this line item transfer is not approved?

APPROVAL SECTION **FOR FIA USE ONLY**

FIA Contract Administrator Name ☐ Approved ☐ Denied	Date
☐ The above request for a line item transfer is approved. The total contract dollar amount has not been affected. If you have any questions, please contact at .	
OCRS Director	Date
☐ The above request for line item transfer has been denied for the following reason.	
OCRS Director	Date

CSBG PROGRAM

LINE ITEM TRANSFERS

RULES

1. **The contract stipulates that any change of more than 10% or $10,000, whichever is greater, of any line item must receive prior approval of the Agency. A line item overrun can be predicted in advance so prior approval can be requested before a billing statement is submitted which exceeds a line item maximum. Transfers will not be approved after expenditures have been made.**

2. **Line item cost flexibility up to 10% or $10,000, whichever is greater, of a line item do not require prior approval. This is a one-time limit. For Example: If a line item is $10,000, a contractor may spend up to $20,000 in the line without prior approval.**

3. **Any increase in a budget line item must be accompanied by an equal decrease somewhere else. The decrease can be spread across a number of line items, as long as the total of all decreases equals the total of all increases. Requests which do not balance increases and decreases will be returned unapproved.**

4. **A line item transfer request must be accompanied by an explanation for the change to each line item. All increases and decreases must be explained fully in the appropriate section. Fully explain the cost items within each line item being changed including reasons why each change is necessary. Add additional pages if provided space is not adequate. Requests for increases in a line item will be judged on the basis of reasonableness, and need. Decreases in line items will be judged on the basis of potential for a negative impact on quantity or quality of service.**

5. **Last minute transfers in an obvious attempt to unnecessarily commit funds will not be allowed. Expenditures must be made in accordance with the budget and in accordance with established Agency policy.**

   If longevity bonuses, merit increases, cost of living allowances, etc., are paid, they must be part of an established personnel policy. Payment of these must be included within the budget, and must be in accordance with established Agency policy.

6. **The Contract Administrator should enter their name, approved or denied and date. If approved, forward via email to OCRS. If denied, return to provider.**

7. **This form (CM-4074) is to be used for all line item transfer requests.**

Notes: Rules adapted for the CSBG Program. 07/02

AUTHORITY: PA 280 of 1939 COMPLETION: Mandatory PENALTY: Unable to adjust budget during term of contract.	The Family Independence Agency will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs know to an FIA Office in your county.

APPLICATION FOR WEATHERIZATION ASSISTANCE

FOR OFFICE USE ONLY		
Weatherization Agency Name:		
Address (Street Number and Name)		
City	State MI	Zip Code
Telephone Number: ( )	Job/Client Number:	
Date of Application:	Date of Eligibility Determination:	

INSTRUCTIONS: THIS APPLICATION MUST BE COMPLETED IN INK. THE APPLICANT SHALL COMPLETE PART I AND PART II. DOCUMENTATION OF ALL SOURCES OF INCOME MUST BE INCLUDED WITH THIS APPLICATION. THE APPLICANT WILL RECEIVE WRITTEN NOTIFICATION OF ELIGIBILITY DETERMINATION.

PART I - GENERAL INFORMATION

(1) NAME (Last, First and Middle)	(2) SOCIAL SECURITY NUMBER			
(3) APPLICANT ADDRESS (Street Number and Name)	(4) CITY	**MI**	(5) ZIP CODE	(6) COUNTY
(7) DIRECTIONS TO THE DWELLING/SPECIAL PROBLEMS AND CONSIDERATIONS				
(8) HOME PHONE NUMBER: ( )	(9) MESSAGE PHONE NUMBER: ( )	(10) NAME OF CONTACT PERSON:	(11) TOTAL NUMBER OF PERSONS IN HOUSEHOLD:	

(12) NUMBER OF PERSONS IN THE HOUSEHOLD WHO ARE OR RECEIVE:	ELDERLY (60+)	DISABLED	NATIVE AMERICAN	FIP*	SSI*	SDA*	FOOD STAMPS	OTHER (DESCRIBE)

* (13) HAS THE APPLICANT OR OTHER HOUSEHOLD MEMBER (S) RECEIVED ASSISTANCE UNDER TITLE IV-A (FAMILY INDEPENDENCE PROGRAM), TITLE XVI (SUPPLEMENTAL SECURITY INCOME) OF THE SOCIAL SECURITY ACT, OR STATE DISABILITY ASSISTANCE (SDA) WITHIN THE LAST 12 MONTHS? ☐ YES ☐ NO

* NOTE: If YES, household is automatically income eligible.

(14) TYPE OF DWELLING	(15) DWELLING OWNERSHIP	(16) RENTAL INFORMATION:
☐ SINGLE FAMILY ☐ MOBILE HOME ☐ MULTI-FAMILY _____TOTAL NUMBER OF UNITS FOR MULIT-FAMILY BUILDING	☐ OWN ☐ RENT ☐ LAND CONTRACT	LANDLORD NAME: ADDRESS: PHONE ( )

(17) IS THIS DWELLING DESIGNATED FOR ACQUISITION OR CLEARANCE BY A FEDERAL, STATE OR LOCAL PROGRAM WITHIN 12 MONTHS? ☐ YES ☐ NO

(18) FUEL TYPE	(19) YEARLY FUEL COST	(20) FUEL VENDOR	(21) FUEL ACCOUNT NUMBER

	$		

APPLICATION FOR WEATHERIZATION ASSISTANCE

PART I (Continued)

(22) IDENTIFY SOURCE AND AMOUNT OF INCOME FOR EACH MEMBER OF THE HOUSEHOLD FOR THE PREVIOUS TWELVE MONTHS. ALL HOUSEHOLD MEMBERS MUST BE LISTED, INCLUDING THOSE WITH NO INCOME.

HOUSEHOLD MEMBER	DATE OF BIRTH	SOCIAL SECURITY NUMBER	SOURCE OF INCOME	AMOUNT OF INCOME

PART II - APPLICANT'S SIGNATURE SECTION

(23) I HEREBY MAKE APPLICATION FOR WEATHERIZATION SERVICES. I UNDERSTAND THAT THE SERVICES ARE PROVIDED FREE OF CHARGE AND ELIGIBILITY IS BASED ON THE TOTAL INCOME OF ALL MEMBERS OF THE HOUSEHOLD FOR THE PREVIOUS TWELVE MONTHS. I CERTIFY THAT ALL THE INFORMATION I PROVIDED IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND THE LOCAL WEATHERIZATION OPERATOR AND/OR DESIGNATED AGENT MAY VERIFY THE INFORMATION IF DEEMED NECESSARY.

I HEREBY AUTHORIZE THE FAMILY INDEPENDENCE AGENCY AND/OR SOCIAL SECURITY ADMINISTRATION TO RELEASE INFORMATION RELATIVE TO ASSISTANCE PAYMENTS RECEIVED.

I HEREBY AUTHORIZE ALL UTILITY COMPANIES TO PROVIDE COPIES OF BILLS OR OTHER INFORMATION ON CONSUMPTION OF FUEL FOR A MINIMUM PERIOD OF 12 MONTHS PRIOR TO WEATHERIZATION AND 12 MONTHS AFTER WEATHERIZATION OF MY HOUSEHOLD.

I HEREBY GRANT PERMISSION FOR THE LOCAL WEATHERIZATION OPERATOR OR ITS SUBCONTRACTORS TO ENTER MY HOME FOR THE PURPOSE OF WEATHERIZATION ASSISTANCE IN ACCORDANCE WITH STATE AND FEDERAL POLICIES. THE LOCAL WEATHERIZATION OPERATOR HAS MY PERMISSION TO PROVIDE STATE OR FEDERAL REPRESENTATIVES WITH MY NAME, ADDRESS, AND PHONE NUMBER. I UNDERSTAND THAT STATE OR FEDERAL AUTHORITIES MAY WISH TO CONTACT ME DIRECTLY ABOUT THE QUALITY AND TYPE OF SERVICES I RECEIVED.

APPLICANT'S SIGNATURE	DATE	INTAKE WORKER'S SIGNATURE	DATE

FOR OFFICE USE ONLY

(A) HOME OWNERSHIP ☐ SELF CERTIFIED ☐ DOCUMENTATION REVIEWED			(B) WAS HOME OWNERSHIP DOCUMENTATION OBTAINED FOR THE CLIENT/JOB FILE? ☐ YES ☐ NO If NO, Describe:	
(C) NUMBER IN HOUSEHOLD :	(D) INCOME POVERTY GUIDELINES:	(E) AMOUNT OF INCOME:	(F1) APPLICANT ELIGIBLE? ☐ YES ☐ NO (F2) 125 % of Poverty? ☐ YES ☐ NO	(G) PRIORITY GROUP ASSIGNED:
(H) WRITTEN ELIGIBILITY NOTIFICATION SENT? ☐ YES ☐ NO IF YES, DATE: _____			(I) APPLICANT PROVIDED WITH THE APPEAL PROCEDURE? ☐ YES ☐ NO	

(J) DWELLING PREVIOUSLY WEATHERIZED? ☐ YES ☐ NO IF YES, DATE:_____	(K) REFERRED TO FIA? ☐ YES ☐ NO	(L) REFERRED TO UTILITY COMPANY? ☐ YES ☐ NO
(M) LOCAL WEATHERIZATION REPRESENTATIVE		(N) DATE DETERMINED ELIGIBLE
(O) MULTI-FAMILY BUILDING ONLY - IDENTIFY JOB/CLIENT NUMBER(S) OF OTHER UNITS BEING WEATHERIZED IN THE BUILDING		

The Local Weatherization Agency will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, political beliefs or disability.

WEATHERIZATION UNIT PRODUCTION SCHEDULE AND COUNTY UNIT PRODUCTION SCHEDULE

Family Independence Agency

AUTHORITY: P.A. 230 of 1981
COMPLETION: MANDATORY
PENALTY: NO FUNDS RELEASED

THE MICHIGAN FAMILY INDEPENDENCE AGENCY WILL NOT DISCRIMINATE AGAINST ANY INDIVIDUAL OR GROUP BECAUSE OF RACE, SEX, RELIGION, AGE, NATIONAL ORIGIN, COLOR, MARITAL STATUS, DISABILITY OR POLITICAL BELIEFS.

NAME OF AGENCY	BEGINNING DATE:	ENDING DATE:

	April	May	June	July	August	September	October	November	December	January	February	March	TOTAL
Monthly Units													
Cumulative Units PYTD													

COUNTY/CITY UNIT PRODUCTION

INSTRUCTIONS: List Total unit completions by county (by city if appropriate), with the corresponding percentage of the total units. Each Subgrantee should determine an equitable production by county or city.

COUNTY/CITY	ESTIMATED UNITS	% OF TOTAL	COUNTY/ CITY	ESTIMATED UNITS	% OF TOTAL
TOTALS			TOTALS		

FIA-4321 (3/03)

Confirmation of Receipt of Lead Pamphlet

Michigan Family Independence Agency

AUTHORITY: 40 CFR PART 745 and Public Act 230 of 1981 COMPLETION: Voluntary PENTALTY: Nome	The Local Weatherization Agency will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make you needs known to a Local Weatherization Office serving your county.

I have received a copy of the pamphlet, *Protect Your Family From Lead In Your Home*, informing me of the potential risk of the lead hazard exposure from renovation activity to be performed in my dwelling. I received this pamphlet before the work began.

_____

Printed name of recipient

Signature of recipient Date

Self-Certification Option (for tenant-occupied dwellings only)—
If the lead pamphlet was delivered but a tenant signature was not obtainable, you may check the appropriate box below.

☐ Refusal to sign—I certify that I have made a good faith effort to deliver the pamphlet, *Protect Your Family From Lead In Your Home*, to the rental dwelling unit listed below at the date and time indicated and that the occupant refused to sign the confirmation of receipt. I further certify that I have left a copy of the pamphlet at the unit with the occupant.

☐ Unavailable for signature—I certify that I have made a good faith effort to deliver the pamphlet, *Protect Your Family From Lead In Your Home*, to the rental dwelling unit listed below and that the occupant was unavailable to sign the confirmation of receipt. I further certify that I have left a copy of the pamphlet at the unit.

_____ _____

Printed name of person certifying lead pamphlet delivery

Attempted delivery dates and times

Signature of person certifying lead pamphlet delivery Date

_____

_____

Unit Address

Note Regarding Mailing Option—As an alternative to delivery in person, you may mail the lead pamphlet to the owner and/or tenant. Pamphlet must be mailed at least 7 days before work begins (Document this process in the case file with a certificate of mailing from the post office attached to a copy of the Agency's letter).

GOALS SUMMARY

Family Independence Agency

AUTHORITY : P.A. 230 of 1981 COMPLETION: MANDATORY PENALTY: NO FUNDS RELEASED	THE FAMILY INDEPENDENCE AGENCY WILL NOT DISCRIMINATE AGAINST ANY INDIVIDUAL OR GROUP BECAUSE OF SEX, RACE, RELIGION, AGE, NATIONAL ORIGIN, COLOR, MARITAL STATUS, DISABILITY OR POLITICAL BELIEFS.
NAME OF AGENCY	PROGRAM YEAR

I. CLIENT PRIORITY GOALS

A. FAMILY INDEPENDENCE PROGRAM (FIP), FOOD STAMPS (FS), STATE DISABILITY ASSISTANCE (SDA), AND SUPPLEMENTAL SECURITY INCOME (SSI) UNITS

a. Total Units To Be Completed: _____ b. Percentage Minimum: 25% c. (a. X b. = Total FIP, FS, SDA, SSI): _____Units (round units up)

B. ELDERLY UNITS (Use 20% as a goal unless other data is available)

a. Total Units To Be Completed: _____ b. Percentage Minimum: _____% c. (a. X b. = Total Elderly Units): _____Units (round units up)

d. Specify Source Of Data Used To Support Percentage If Not Using 20%:

C. DISABLED UNITS (Use 15% as a goal unless other data is available)

a. Total Units To Be Completed: _____ b. Percentage Minimum: _____% c. (a. X b. = Total Disabled Units): _____Units (round units up)

d. Specify Source Of Data Used To Support Percentage If Not Using 15%:

II. OTHER GROUPS TO BE SERVED

A. 125% OF POVERTY

a. Total Units To Be Completed: _____ b. Percentage Minimum 50.1% c. (a. x b. = Total Poverty Units): _____Units (round units up)

B. NATIVE AMERICAN UNITS (FIA has no set priority percentage but expects subgrantees to make efforts to proportionately serve Native Americans.)

a. Estimate The Number Of Low-Income Native American Households In Your Service Area: _____ b. Estimate The Number Of Native American Units To Be Served: _____

c. Specify Source Data Used To Determined Number In Your Service Area:

IV. UNIT COST SUMMARY

A Completed Unit: All weatherization materials have been installed and a final inspection completed.

A. Average Cost Per Unit: Material + Support + Labor ÷ Total Units = $_____ **(Cannot exceed $2568 per unit)**

ENCLOSURE 1 - M

PROGRAM ACCOUNT BUDGET I

INSTRUCTIONS FOR COMPLETING

BUDGET SUMMARY

COLUMN 1 (TOTAL BUDGET):

Enter the total sum of columns 2 and 3.

COLUMNS 2 and 3:

Enter cost totals by appropriate source.

COST CATEGORY BUDGET COLUMNS: See **CSPM Item 402.1 - Program Accounts & Cost Categories for CSBG** for additional budgeting instructions.

SALARIES/WAGES (Enter total WAGES from Program Account Budget II)

For the following cost categories, enter the total planned costs .

FRINGE BENEFITS (e.g., benefits paid by the employer)

OCCUPANCY/SPACE (e.g., space and utilities)

COMMUNICATION (e.g., telephone service, telegraph, WATS, centrex, postage, messenger service and similar expenses; printing and reproduction costs; etc.)

SUPPLIES (e.g., consumable supplies, items not meeting the definition of equipment)

EQUIPMENT (e.g., purchases, rental, delivery and freight costs)

TRAVEL (e.g., meals/lodging/transportation; per diem or mileage; vehicle insurance, gasoline, oil, or depreciation)

CONTRACTUAL SERVICES
(e.g., audits, needs assessments, payroll/accounting services, etc.)

SPECIFIC ASSISTANCE TO INDIVIDUALS
(e.g., food or food vouchers, service vouchers, transportation services, rent deposit, rental payment, contracts for specific services)

MISCELLANEOUS (e.g., Aindirect costs@; direct administrative costs charged/assessed by a governmental unit such as a City or County; agency liability insurance or employee bonds; agency annual meeting or conference costs; dialogue on poverty; employee or board conference/training registration fees; etc.)

TOTAL COSTS:

Enter a TOTAL for each column with dollar figures.

PROGRAM ACCOUNT BUDGET I

Michigan Family Independence Agency

DATE SUBMITTED:	PAGE NUMBER: 1 OF ___

NAME OF AGENCY:	COMPLETION: MANDATORY PENALTY: NO FUNDS RELEASED	THE MICHIGAN FAMILY INDEPENDENCE AGENCY WILL NOT DISCRIMINATE AGAINST ANY INDIVIDUAL OR GROUP BECAUSE OF RACE, SEX, RELIGION, AGE, NATIONAL ORIGIN, COLOR, MARITAL STATUS, DISABILITY OR POLITICAL BELIEFS.

PROGRAM ACCOUNT

PROGRAM ACCOUNT NUMBER AND NAME: (COMPOSITE - PA01-ADM - PA02-DIRECT PROGRAM)	TYPE OF BUDGET: 9 PROGRAM ACCOUNT 9 COMPOSITE	BEGINNING DATE:	ENDING DATE:	SUBMITTED AS PART OF: 9 INITIAL PLAN BUDGET 9 MODIFICATION/AMENDED BUDGET

BUDGET SUMMARY

COST CATEGORY	(1) CSBG TOTAL	(2) CSBG FORMULA	(3) CSBG-D T/TA	(4)	(5)	(6)
SALARIES/WAGES						
FRINGE BENEFITS						
OCCUPANCY/SPACE						
COMMUNICATION						
SUPPLIES						
EQUIPMENT						
LOCAL TRANSPORTATION						
CONTRACTUAL SERVICES						
SPECIFIC ASSISTANCE TO INDIVIDUALS						
MISCELLANEOUS						
TOTAL COSTS				N/A	N/A	N/A

PROGRAM ACCOUNT BUDGET II

INSTRUCTIONS FOR COMPLETING

SALARIES/WAGES

COLUMN A - POSITIONS:

Enter the title used to describe each position budgeted.

Note: If the position is part-time, include Ap-t@ following the position title.

COLUMN B - ANNUALIZED SALARY: (For each position in Column A)

1. If the position is full-time, full-year, enter the amount of salary the position would pay if it were a full-time, full-year job (2080 hours).

2. If the position is part-time, enter the amount of salary the position pays as part-time.

3. Add the figures in the column and enter the total dollars on the Totals line.

COLUMN C - CSBG SHARE:

1. Enter total dollars planned to be charged to CSBG funds for each position.

2. Add the figures in the column and enter the total dollars on the Totals line.

COLUMN D - CSBG PERCENT of Annualized Salary:

1. Calculate the percentage of the annualized, or part-time, salary that CSBG dollars will support and enter the percentage for each position. **Note**: Round to the nearest full percentage point; e.g. 79.6% would be 80%.

2. Based on the total dollars in columns AB@ and AC@, calculate the percentage of CSBG dollars and enter the percent on the Totals line. **Note**: Round to the nearest full percentage point.

COLUMNS E thru G:

N/A

GENERAL:

1. A separate Program Account Budget II must be completed for each program account.
2. Do not put consultant or fringe costs on this page.
3. Do not put volunteer hours on this page.

PROGRAM ACCOUNT BUDGET II

Michigan Family Independence Agency

DATE SUBMITTED:	PAGE NUMBER: ___ OF ___

NAME OF AGENCY:	COMPLETION: MANDATORY PENALTY: NO FUNDS RELEASED	THE MICHIGANIGAN FAMILY INDEPENDENCE AGENCY WILL NOT DISCRIMINATE AGAINST ANY INDIVIDUAL OR GROUP BECAUSE OF RACE, SEX, RELIGION, AGE, NATIONAL ORIGIN, COLOR, MARITAL STATUS, DISABILITY OR POLITICAL BELIEFS.

PROGRAM ACCOUNT Number and Name:

SALARIES/WAGES

A. POSITIONS (TITLE OF EACH POSITION--One Person Per Line)	B. ANNUALIZED SALARY	C. CSBG SHARE BUDGETED AMOUNT	D . CSBG PERCENT (%) of Annualized Salary	E. N/A	F. N/A	G. N/A
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
TOTALS						

PROGRAM ACCOUNT BUDGET III

INSTRUCTIONS FOR COMPLETING

BUDGET SUPPORT DATA

Line Item OCCUPANCY/SPACE:

List each facility, **by address and facility purpose**, supported under this budget. Provide the amount budgeted under CSBG for each facility. Costs for Aoffice space@ must include a designation as either **rent**, **depreciation** or **use allowance**. Since Aspace@ must be designated as either rent, depreciation or use allowance, Autilities@ and Amaintenance@ costs should be noted separately.

- OMB Circulars A-122 and A-87 require that compensation for the use of **agency-owned** buildings must be made through use allowances or depreciation.

Examples:	Eaton County Outreach Office, 222 Main Street, Grand Ledge (**rent**)	3,000
	Central Office, 425 Beach Street, Muskegon (**depreciation**)	5,000

Line Item SUPPLIES:

Itemize any individual non-consumable item (e.g., furniture, computers, computer hardware, etc.) costing between $1,000 and $4,999 AND any computer software purchase costing $1,000 or more.

- Each cost budgeted must include a designation as either **purchase** or **rent**.
- Items purchased for clients are to be included under the line item ASpecific Assistance to Individuals.@
- Computer software is always considered a Asupply@ regardless of cost and must be itemized under the Asupplies@ line item if the cost is $1,000 or more.

Examples:	Conference room tables and chairs (**purchase**)	5,000	
	EZ Track 2000 Software (**purchase**)		9,000
	2 Computers (**purchase**)		4,000
	Copy Machine (**rent**)		2,000

Line Item EQUIPMENT:

Itemize each cost budgeted under equipment.

- **$** Equipment (as defined by the OMB Circulars A-122 and A-87) is as an article of nonexpendable, tangible personal property having a useful life of more than one year and an acquisition cost of $5,000 or more.

- **$** Equipment purchases cannot be expensed directly to the CSBG grant; these costs must be capitalized and may be budgeted as either depreciation or use allowance. (See CSPM Item 404 - Equipment)

  Note: **Waiver Process**: As part of the grantee=s budget application process, FIA will accept formal waiver requests to purchase Aequipment.@ Agencies submitting a request must do so by utilizing the Equipment Waiver Request form, FIA-4328, and by providing the required documentation with their CSBG Budget application. Purchases cannot occur until a waiver has been granted.

- **$** Compensation for the use of **agency-owned** equipment must be made through either a use allowance or depreciation. If the initial purchase cost was $5,000 or more, the use allowance or depreciation cost for the budget year must be itemized, even though the use allowance or depreciation cost may be under $5,000.

- **$** All items budgeted under this line item must include a designation as either **purchase**, **rent**, **depreciation** or **use allowance**. If a waiver is being requested to purchase Aequipment,@ it should be noted; see the example below.

Examples:	Equipment for Soup Kitchen (**depreciation**)	4,000	
	Transportation Program Van (**use allowance**)	4,000	
	Senior Program Van (**rent**)		5,200
	Agency Telephone System (**purchase/waiver request attached**)		9,800

Line Item CONTRACTUAL SERVICES:

Itemize each contracted service and include a brief description for each.

- **$** Contracts to provide assistance/training/etc. to/for clients are to be included under the line item ASpecific Assistance to Individuals.@

Examples:	CSBG Audit	1,200
	Consultant to develop Needs Assessment Survey form and to compile data	4,500
	Accounting/Payroll Services	3,000
	Marketing Consultant/Marketing Services	5,000

Line Item SPECIFIC ASSISTANCE TO INDIVIDUALS:

Specific services provided to and for clients (such as the purchase of household supplies or furniture, payment of utility bills, or the provision of training, meals, shelter, transportation, etc.) are to be budgeted under this line item. Itemize each type of specific assistance.

- If the agency plans to contract with another provider to provide specific services for clients (such as noted above), the agency must identify both the service and the contractor=s name, and include the following items in its plan.

    1. A copy of the contract=s scope of services: The scope must specifically identify the services to be provided to the clients. It must also indicate wich entity, the agency or the contractor, will determine client eligibility. If the contractor is to determine eligibility, the CSBG eligibility guidelines must be referenced (example: CSPM Item 502 - CSBG Income Eligibility Guidelines, effective 02/14/02), and noted as attached.
    2. A copy of the proposed budget.

$ RE: Agencies using more than one funding source to provide specific assistance: If an agency contracts with another service provider to provide specific services to its clients (including emergency services) with both CSBG and another FIA fund source (such as TANF or MPSC), there must be a separate contract, scope of services and budget for each funding source.

Examples:	Automotive Repairs	3,000
	Medical/Dental Vouchers	2,000
	Food Baskets	1,800
	Rent Deposits	5,000
	Utility Payments	3,000
	Food Vouchers	1,500
	Overnight Shelter (**thru Women=s Rescue Mission**)	9,000
	Family Services/Counseling (**thru Operation Get Down**)	6,000
	Housing Dispute Mediation (**thru Tri-Co. Legal Services**)	4,000
	Transportation (**thru Blue Cab**)	4,000

Line Item MISCELLANEOUS:

The following costs must be itemized:

- Indirect Costs (A copy of the latest approved Indirect Cost Rate Agreement, from the cognizant agency, must be included with the budget.)
  Such costs are to be included in the PA 01 - ADM budget.

- Direct costs (similar to indirect costs) assessed by a governmental unit.
  Such costs are to be included in the PA 01 - ADM budget.

- Membership dues to state and national associations.*
  Such costs are to be included in the PA 01 - ADM budget.

- Membership dues to community, civic or social organizations.*
  Such costs are to be included in the PA 01 - ADM budget.

- Miscellaneous individual costs of $1,000 or more.

* Refer to: **OMB Circular A-122 (Revised 06/01/98)**
- Cost Principles for Non-Profit Organizations
- Attachment B--Item 30., d.

OMB Circular A-87 (Revised 05/04/95, As Further Amended 08/22/97)
- Cost Principles for State, Local and Indian Tribal Organizations
- Attachment B--Item 30., d.

Examples:

Indirect Costs (Rate 5%-see attached rate agreement)		12,500
Direct costs assessed by the County		3,000
MCAAA dues		800
NACAA dues		300
NASCASP dues		300
Multi-Purpose Collaborative Body dues	200	
Inter-Agency Council dues	200	
Regional Chamber of Commerce dues	100	
Urban League dues		100
Agency General Liability Ins.		1,500
Agency Board Errors & Omissions Ins.		1,500
Agency Annual Meeting (food, space, etc.)		1,000
Agency Annual Report and Informational Brochures	2,000	
MCAAA conference registration		1,200
Employee skills upgrade training fees		2,000

PROGRAM ACCOUNT BUDGET III Michigan Family Independence Agency	DATE SUBMITTED:	PAGE NUMBER: ___ OF ___

NAME OF AGENCY:	COMPLETION: MANDATORY PENALTY: NO FUNDS RELEASED	THE MICHIGAN FAMILY INDEPENDENCE AGENCY WILL NOT DISCRIMINATE AGAINST ANY INDIVIDUAL OR GROUP BECAUSE OF RACE, SEX, RELIGION, AGE, NATIONAL ORIGIN, COLOR, MARITAL STATUS, DISABILITY OR POLITICAL BELIEFS.

PROGRAM ACCOUNT

PROGRAM ACCOUNT NUMBER AND NAME:	BEGINNING DATE:	ENDING DATE:

BUDGET SUPPORT DATA

OCCUPANCY/SPACE: List each facility, by address and facility purpose, and include a designation as either **rent**, **depreciation** or **use allowance**. List utility costs separately.

SUPPLIES: Itemize each individual non-consumable item (e.g., furniture, computers, computer hardware, etc.) costing between $1,000 and $4,999 AND any computer software purchase costing $1,000 or more. Include a designation as either **rent** or **purchase** for each item.

EQUIPMENT: Itemize each individual equipment cost budgeted. Each item must include a designation as either **rent**, **depreciation**, **use allowance** or **purchase (waiver required)**.

CONTRACTUAL SERVICES: Itemize each contracted service and include a brief description for each. (Include contracts to provide services for clients under the S.A.toI. line item.)

SPECIFIC ASSISTANCE TO INDIVIDUALS: Itemize each type of specific assistance (e.g., dental services, rent). If provided by a contractor, include the name of the contractor.

MISCELLANEOUS: Itemize: Indirect Costs (include a copy of the Indirect Cost Rate Plan); direct costs assessed by a governmental unit; dues for state/national associations, community, civic and social organizations; **and** individual costs of $1,000 or more.

STATEMENT OF EXPENDITURES

Michigan Family Independence Agency

Authority: P.A. 230 of 1981

ORIGINAL FIA RECEIPT
(For FIA Use Only)

1. Contract Number

SECTION I. Complete for All Submittals

2. Grantee Name	3. Authorized FIA Signature(s)	5. Approval Date
4. Report Month/Year		6. F.E. Number

7. Agency	8. App. Year	9. Index	10. P.C.A.	11. Agency Code	12. Agency Object	13. Mail Code
431						

SECTION II. Bill Type

☐ Original ☐ Revised ☐ Final ☐ Other ☐ DOE ☐ LIHEAP ☐ Other _____

SECTION III. Reported Expenditures

BUDGET LINE ITEM	APPROVED BUDGET	PREVIOUSLY REPORTED EXPENDITURES	EXPENDITURES THIS PERIOD	EXPENDITURES YEAR-TO-DATE	BUDGET BALANCE	OTHER INCOME YEAR-TO-DATE EXPENDITURES
1. Labor						
2. Materials						
3. Support						
4. Subtotal						
5. Vehicle Purchase (If amortizing in Sec. V, Line 2 include here. Otherwise report in Support Line 3.) All vehicle purchases require completion of FIA–4326-A.						
6. Administration						
7. T/TA						
8. Liability Insurance						
9. Financial Audit						
10. Total						

SECTION IV. Other Income

Other Income Received Program Year-to-Date	Source(s) of Other Income (i.e., program income, landlord contributions, interest income)
$	

SECTION V. Average Cost Per Unit

1. Total Labor, Support, Materials PYTD (Section III, Line 4)		
2. **PYTD** Amortized Vehicle Cost	+	
3. Health and Safety Cost (Section VI, Line 1) (subtract)	-	
4. Total Cost (Line 1 + Line 2 - Line 3)		
5. Total Units Completed PYTD (Do not include LIHEAP-only units)		
6 Average Cost Per Unit (Line 4 ÷ Line 5)		

SECTION VI. Average Health and Safety Cost

1. Total Health and Safety Expenditures PYTD	
2. Total Units Completed PYTD (Do not include LIHEAP-only units)	
3. Average Health and Safety Cost Per Unit (Line 1 ÷ Line 2)	

SECTION VII. Total Repair Cost

Total PYTD Repair Cost	

COMMENTS

I hereby certify that I am authorized to sign on behalf of the local agency and that this is a correct statement of expenditures for the report period identified above. Appropriate documentation is available and will be maintained for the required report period to support the reported costs.

Signature	Title	Date

Weatherization Assistance Program **Vehicle Purchase** Michigan Family Independence Agency Authority: P.A. 230 of 1981		1. Contract Number

SECTION I. Complete for ALL vehicle purchases

2. Grantee Name	ORIGINAL FIA RECEIPT(For FIA Use Only)
3. Report Month/Year	

Vehicle # 1	Vehicle # 2	Vehicle # 3
Make, Model and Year of Vehicle	Make, Model and Year of Vehicle	Make, Model and Year of Vehicle
Date of Purchase	Date of Purchase	Date of Purchase
Vehicle Purchase Price	Vehicle Purchase Price	Vehicle Purchase Price

SECTION II. Amortizing Report (Complete this section monthly if amortizing cost)

Number of Years of Amortization		Number of Years of Amortization		Number of Years of Amortization	
Monthly Amortization Amount		Monthly Amortization Amount		Monthly Amortization Amount	
Number of Months Amortized since purchase		Number of Months Amortized since purchase		Number of Months Amortized since purchase	
Amount Amortized since purchase		Amount Amortized since purchase		Amount Amortized since purchase	
Amount Amortized PYTD This must agree with FIA-4326,Section V, line 2		Amount Amortized PYTD This must agree with FIA-4326, Section V, line 2		Amount Amortized PYTD This must agree with FIA-4326, Section V, line 2	

COMMENTS

I hereby certify that I am authorized to sign on behalf of the local agency and that this is correct information for the report period identified above. Appropriate documentation is available and will be maintained for the required report period to support the reported costs.

Signature	Title	Date

Program Account Budget I - WEATHERIZATION ASSISTANCE PROGRAM Family Independence Agency	Date Submitted:	Page _____of _____
AGENCY NAME:	AUTHORITY : P.A. 230 of 1981 COMPLETION: MANDATORY PENALTY : NO FUNDS RELEASED	THE MICHIGAN FAMILY INDEPENDENCE AGENCY WILL NOT DISCRIMINATE AGAINST ANY INDIVIDUAL OR GROUP BECAUSE OF RACE, SEX, RELIGION, AGE, NATIONAL ORIGIN, COLOR, MARITAL STATUS, DISABILITY OR POLITICAL BELIEFS.

PROGRAM NAME:	TYPE OF BUDGET	BEGINNING DATE:	ENDING DATE:	SUBMITTED AS PART OF:
Department of Energy	[ ] Program Account [ ] Composite			[ ] Funding Request [ ] Amendment Request

BUDGET SUMMARY

COST CATEGORY NUMBER	COST CATEGORY	TOTAL BUDGET (1)	ADMIN (2)	T & TA (3)	SUPPORT (4)	LABOR (5)	MATERIALS (6)	LIABILITY INSURANCE (7)	FINANCIAL AUDIT (8)
1.1	WAGES								
1.2	FRINGE BENEFITS								
1.3	CONSULTANTS AND CONTRACT SERVICES								
2.1	TRAVEL								
2.2	SPACE COSTS								
2.3	CONSUMABLE SUPPLIES								
2.4	EQUIPMENT								
2.5	OTHER COSTS								
TOTAL COSTS:									

Program Account Budget II --Weatherization Assistance Program Family Independence Agency	Date Submitted:	Page _____of _____
AGENCY NAME:	AUTHORITY : P.A. 230 of 1981 COMPLETION: MANDATORY PENALTY : NO FUNDS RELEASED	THE MICHIGAN FAMILY INDEPENDENCE AGENCY WILL NOT DISCRIMINATE AGAINST ANY INDIVIDUAL OR GROUP BECAUSE OF RACE, SEX, RELIGION, AGE, NATIONAL ORIGIN, COLOR, MARITAL STATUS, DISABILITY OR POLITICAL BELIEFS.

WAGES

POSITION Title of Each Position (one Person Per Line)	ANNUALIZED SALARY	TOTAL PROGRAM	ADMIN	T & TA	SUPPORT	LABOR
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
TOTALS						

Program Account Budget III - Weatherization Assistance Program

Family Independence Agency

Date Submitted:

Page _____of _____

AGENCY NAME:	BEGINNING DATE:	ENDING DATE:	AUTHORITY : P.A. 230 of 1981 COMPLETION: MANDATORY PENALTY : NO FUNDS RELEASED	THE MICHIGAN FAMILY INDEPENDENCE AGENCY WILL NOT DISCRIMINATE AGAINST ANY INDIVIDUAL OR GROUP BECAUSE OF RACE, SEX, RELIGION, AGE, NATIONAL ORIGIN, COLOR, MARITAL STATUS, DISABILITY OR POLITICAL BELIEFS.

BUDGET SUPPORT DATA

COST CAT. NO. (1)	DESCRIPTION OF ITEM AND BASIS FOR VALUATION (2)	BUDGETED AMOUNT							
		TOTAL (3)	ADMIN (4)	T/TA (5)	SUPPORT (6)	LABOR (7)	MATERIALS (8)	LIABILITY INS. (9)	FINANCIAL AUDIT (10)
	POLLUTION OCCURRENCE INSURANCE								
	OTHER LIABILITY INSURANCE								
PAGE SUBTOTALS									
PRECEDING PAGE TOTALS									
TOTALS									

ISSUANCES AFFECTED:

A. REFERENCES Community Services Block Grant Agreement

Weatherization Assistance Program Agreement

State Emergency Funds Agreement

B. RESCISSIONS None

BACKGROUND:

A Grantee's plan may be modified whenever the Grantee proposes to: change the types of activities in the approved plan; the Grantee's expenditures are expected to exceed allowable budget flexibility limitations; as determined by the Agency because of funding level changes; or the Agency requests a modification to ensure maximum production and expenditure of program funds.

POLICY:

Section II.C.2. of each of the agreements above states:

> The plan modification request must be submitted on Form FIA-1058 and signed by the Grantee's executive director and board chairperson or authorized designee. The plan modification request must be accompanied by appropriate documentation as required by the Agency.

The Grantee is required to complete a Modification Request, FIA-1058, for any of the changes identified above. The Program Account Budget I, FIA-4323 and DOE/LIHEAP Program Account Budget I, FIA-4375 must accompany the Modification Request for any line item changes to the budget. See Item 202 for forms. Appropriate documentation for other changes will be determined by the Agency.

Four copies, two copies with original signatures, of the Modification Request will be submitted to:

Family Independence Agency
Grand Tower, Suite 1313
P.O. Box 30037
235 South Grand Avenue
Lansing, Michigan 48909

One original signature copy will be returned to the Grantee with the appropriate Agreement Amendment upon approval.

MICHIGAN FAMILY INDEPENDENCE AGENCY		Item 204	Page 1 of 1
Community **S**ervices **P**olicy **M**anual	SUBJECT General Policy: **BOARD OF DIRECTORS CHANGES**		•**EFFECTIVE DATE** 01/01/00 •**END DATE** N/A •**ISSUE DATE** 12/08/99

ISSUANCES AFFECTED:

REFERENCES:
- Master Agreement

RECISIONS:
- None

BACKGROUND:

Section 26 of the Master Agreement states:

> The Grantee shall inform FIA of any changes in its Board in the following instances:
>
> - as part of the Grantee's annual CSBG community action plan,
> - within 30 days following the Grantee's annual elections, and
> - within 30 days following changes in the Chairperson/President

For the above instances, the Grantee shall submit the Community Action Agency Board Roster (FIA-1057) to inform FIA of the board changes.

POLICY:

The Grantee is required to submit the CAA Board Roster, FIA-1057, whenever the above circumstances occur. See Item 202 for forms.

The board roster shall be submitted to the Grantee's FIA grant manager at the following address:

Family Independence Agency
Grand Tower, Suite 1313
P O Box 30037
235 South Grand Avenue
Lansing, Michigan 48909

ISSUANCES AFFECTED:

A. REFERENCES R400.19201 of the Community Action Program Administrative Rules of 1990

R400.19404 of the Community Action Program Administrative Rules of 1990

B. RESCISSIONS None

BACKGROUND:

R400.19201(5) of the Community Action Program Administrative Rules of 1990 requires the Agency to establish guidelines for receiving and processing appeals requests for the following:

a. Applicants who are denied a service funded by the Agency.

b. Grantees that are denied a contract or have funding terminated for cause.

c. A Community Action Agency whose designation status has been rescinded or altered for cause.

d. Contractors that are denied a contract or have funding terminated for cause.

POLICY:

R400.19404(1) of the Community Action Program Administrative Rules of 1990 requires the Grantee to establish an appeals mechanism which provides the opportunity to appeal any of the following:

a. An application for a low-income service if there has been a partial or complete denial of assistance and if all of the following provisions have been satisfied:

   1. The services denied are specific, tangible benefits for which the Agency provides funding.

   2. Funds are currently available.

   3. The Grantee has the authority to provide or disburse funds.

   4. The applicant has completed a formal, written application for such services.

5. The applicant falls within the program guidelines or believes that they can prove they fall within the program guidelines.

b. A service provider's contract has been suspended, terminated, or not renewed.

c. A contractor's or potential contractor's application or proposal to provide services was denied.

d. An administrative action that limits or imposes requirements on the contractor or service provider.

R400.19404(2) of the Community Action Program Administrative Rules of 1990 requires the Grantee, through the action of its Governing Board, to establish and issue an appeals procedure for the items covered in R400.19404(1)a and b above which will include all of the following:

a. Written notice to the applicant, contractor, or service provider of the Grantee's action to suspend, terminate, not renew, or deny a contract or service, including a notice of the right to appeal.

b. Notice that information or criteria on which the Grantee's action was based is available for review by the affected parties.

c. Notice that the affected party may appear in person or through a designated representative to appeal the Grantee's action.

d. Provision for, as the initial step of any appeal, a meeting with the governing body within 30 days to review items in dispute and seek clarification or resolution to the dispute.

   A record of the meeting, including relevant facts, will be maintained and a determination rendered, in writing, by the governing body. Unresolved issues may be appealed to arbitration.

e. A specification that appeals proceedings will be conducted within an aggregate time frame of 60 days, within which time all of the following must occur:
   1. A notice of the right to appeal will be sent to the affected party within 20 days of the Grantee's action.

   2. Any formal appeal will be requested in writing by the affected party or parties within 10 days notice pursuant to the provisions of the item above.

   3. Upon receipt of an appeal request, a hearing will be conducted. The decision rendered will be in writing to the affected party or parties.

f. Notice must be provided that a Grantee's hearing decision may be appealed to the Agency which will review and act on the appeal pursuant to R400.19201(5).

g. A description of the circumstances under which a request for an appeal hearing may be refused. Such circumstances are limited to the failure to comply with the appeal procedures required by R400.19404(2) or to lack of standing by the appellant.

R400.19404(3) of the Community Action Program Administrative Rules of 1990 requires the Grantee, through the action of its Governing Board, to establish and issue an appeals procedure for the items covered in R400.19404(1)c above which will include all of the following:

a. Written notice to all denied applicants, contractors, or service providers of the administrative appeals process.

b. Written notice that denied applicants, contractors, or service providers may appeal administrative complaints to the Grantee's governing body.

c. Written notice to the appellant of the governing body's determination within 30 days of the appeal's filing date.

d. Written notice of the decision must include a statement that appellants may appeal the decision to the Agency within 10 days of the written notice provided above.

All procedures are to be submitted to the Agency for review of content and form before final adoption.
A complainant may file an appeal of the Grantee's decision within 15 days of the written decision by the Grantee or within 15 days of when the decision should have been made. The written appeal must be submitted to:

Family Independence Agency
Administrative Hearings
P.O. Box 30037
235 South Grand Avenue
Lansing, Michigan 48909

The written appeal must be in writing and should include, to the extent possible, the following information:

1. A copy of the original appeal and all correspondence relating to the appeal.

2. The full name, address, and telephone number of the person(s) making the appeal.

3. The full name and address of the party against whom the appeal is made, or other information sufficient to identify the party against whom the appeal is made.

4. A clear and concise statement of the facts, as alleged, including pertinent dates, constituting the alleged violation.

5. The provision of the act, regulation, grant, or other agreements believed to have been violated.

6. The relief requested.

The decision rendered by Administrative Hearings is the final step in the appeal procedure.

ISSUANCES AFFECTED: A. REFERENCES Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended

BACKGROUND: The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as amended, establishes requirements for receipt of federal, state and local public funds by aliens.

POLICY:

CSBG, Weatherization, State Emergency Funds, and LIHEAP

A person must be a U.S. citizen or have an acceptable alien status to be eligible for CSBG, Weatherization Assistance Program, LIHEAP or State Emergency Funds (SEF). Persons who do not meet these requirements or who refuse to indicate their status are not eligible. Illegal aliens are not eligible.

The following aliens meet the alien status requirement:

- A refugee who is admitted under section 207 of the Immigration and Nationality Act (INA)
- An alien who is granted asylum under INA section 208
- An alien whose deportation is being withheld under INA section 241(b)(3) or 243(h)
- An alien granted conditional entry under INA section 203(a)(7)
- A person born in Canada, who is at least 50% American Indian
- Permanent resident alien (all class codes)
- An alien who is paroled under section 212(d)(5) of the Immigration and Nationality Act
- Non-immigrants (e.g., students and tourists)
- Cuban/Haitian Immigrants

Verification

Do not request verification of U.S. citizenship unless questionable. Acceptable documents to verify citizenship/alien status include:

- Birth certificate or other birth record
- U.S. passport
- Voter registration card
- Naturalization papers or INS identification card

An applicant's signed statement is also acceptable verification of citizenship/alien status. Page 3 of this item is a sample format which can be used.

Documentation must be included in the applicant's file.

Weatherization Assistance Program

Until we receive specific direction from the federal government, continue current citizenship/alien status procedures for all applications for DOE Weatherization services.

Citizenship/Alien Status Statement

Applicant Name: _____

***Applicant Identifier (birth date, SSN, etc.): _____

Agency: _____

I certify that I am __(Enter “a U.S. citizen” or the appropriate alien status)_____

_____

_____

_____

_____
Signature

_____
Date

***** Enter if needed for internal tracking

MICHIGAN FAMILY INDEPENDENCE AGENCY		Item 207	Page 1 of 1
Community **S**ervices **P**olicy **M**anual	SUBJECT General Policy: **BY-LAWS and ARTICLES OF INCORPORATION – CHANGES and AMENDMENTS**		· **EFFECTIVE DATE** 01/01/00 · **END DATE** N/A · **ISSUE DATE** 12/08/99

ISSUANCES AFFECTED:

REFERENCES

- The CSBG Act, P.L. 97-35 of 1981, as amended by the Coats Human Services Reauthorization Act of 1998.

PURPOSE:

To provide guidelines for the submission of information pertaining to an agency's designation, purpose and rules governing its internal affairs.

BACKGROUND:

Pursuant to the CSBG Act, Sections 676 and 678B, it is the duty of the state to conduct evaluations and reviews of eligible entities (*CAAs*) to determine whether they meet the performance goals, administrative standards, financial management requirements and other requirements as set by the state.

Such evaluations will include an ongoing review of the CAA's designation status (found in its Articles of Incorporation) and purpose and rules governing its internal affairs (found in its By-Laws).

POLICY:

- The Grantee is required to submit one copy of changes/amendments to its By-Laws within 30 days following Board approval.
- The Grantee is required to submit one copy of changes/amendments to its Articles of Incorporation within 30 days following receipt of documentation of filing with the State of Michigan. **Note**: For public CAAs, the Grantee shall submit a copy of official changes enacted by its local unit of government concerning the Grantee's status or purpose within that unit.

These documents shall be submitted to the Grantee's FIA grant manager at the following address:

Family Independence Agency
Grand Tower, Suite 1313
P O Box 30037
235 South Grand Avenue
Lansing, Michigan 48909

REFERENCES: Federal Register, Volume 69 No. 30, Pages 7335 – 7338; February 13, 2004

FIA Agreements and Contracts

BACKGROUND:

The annual update of the U.S. Department of Health and Human Services poverty guidelines was published on February 13, 2004, in the Federal Register, Volume 69, No. 30, Pages 7335 – 7338.

POLICY:

The Grantee is required to use the poverty income guidelines to determine eligibility for FIA-funded activities. The table included on page 2 of this item includes the poverty income guidelines effective February 13, 2004.

The Grantee is required to provide programmatic reports for FIA-funded activities. These reports include household income information. The table on page 2 of this item includes the income ranges to be used when collecting household income information for programmatic reporting purposes.

POVERTY RATE TABLE

Effective February 13, 2004

Size of Family Unit	**75% of Poverty**	**100% of Poverty**	**125% of Poverty**	**150% of Poverty**	**200% of Poverty**
1	$6,983	$9,310	$11,638	$13,965	$18,620
2	$9,368	$12,490	$15,613	$18,735	$24,980
3	$11,753	$15,670	$19,588	$23,505	$31,340
4	$14,138	$18,850	$23,563	$28,275	$37,700
5	$16,523	$22,030	$27,538	$33,045	$44,060
6	$18,908	$25,210	$31,513	$37,815	$50,420
7	$21,293	$28,390	$35,488	$42,585	$56,780
8	$23,678	$31,570	$39,463	$47,355	$63,140
Each additional member					
ADD	$2,385	$3,180	$3,975	$4,770	$6,360

Size of Family Unit	**75% of Poverty 30 days**	**100% of Poverty 30 days**	**125% of Poverty 30 days**	**150% of Poverty 30 days**	**200% of Poverty 30 days**
1	$582	$776	$970	$1,164	$1,552
2	$781	$1,041	$1,301	$1,561	$2,082
3	$979	$1,306	$1,632	$1,959	$2,612
4	$1,178	$1,571	$1,964	$2,356	$3,142
5	$1,377	$1,836	$2,295	$2,754	$3,672
6	$1,576	$2,101	$2,626	$3,151	$4,202
7	$1,774	$2,366	$2,957	$3,549	$4,732
8	$1,973	$2,631	$3,289	$3,946	$5,262
Each additional member					
ADD	$199	$265	$331	$398	$530